THE EFFECTS OF COMORBIDITY, PRESCRIPTION DRUG USE, AND MEDICAL UTILIZATION ON DULOXETINE INITIATION IN PATIENTS WITH FIBROMYALGIA

White LA1, Birnbaum H1, Samuels S1, Kaltenboeck A1, Yu AP1, Mallett D2, Robinson RL2

1Analysis Group, Inc, Boston, MA, USA, 2Ingenix Employer Solutions, New Haven, CT, USA, 3Eli Lilly and Company, Indianapolis, IN, USA

OBJECTIVE: Investigate factors predicting duloxetine initiation among fibromyalgia patients. METHODS: Using Cox proportional hazards models, we investigated effects of baseline health characteristics among fibromyalgia patients on time to duloxetine initiation from the later of index date (duloxetine market entry (August 1, 2004)) or first fibromyalgia diagnosis. Characteristics measured in the six-month pre-index period included demographics, comorbidities, use of medications recommended by American Pain Society (APS), specialty physician services, and fibromyalgia diagnosis stage (newly-diagnosed, established). It included 7965 patients with 2+ fibromyalgia claims (ICD-9 729.1) who were continuously eligible from February 1, 2004 through December 31, 2005. A total of 495 (6.2%) had a prescription for duloxetine during the study period. Time to initiation was measured from index date to the first duloxetine prescription. Observations were right-censored if they did not initiate on duloxetine during the study period. As duloxetine initiation was strongly associated with established diagnosis, separate models were estimated for 5353 newly-diagnosed and 2612 established patients. RESULTS: Baseline medication use served as the strongest predictor of duloxetine initiation. Use of alpha-2-delta ligands, venlafaxine, SSRIs, other antidepressants, opioid analgesics, and non-benzodiazepine sedatives all were strong predictors of initiation (all p < 0.05). Dopamine agonists and venlafaxine (hazard ratios: 2.913; 2.338) were the strongest for newly-diagnosed, and alpha-2 delta ligands and SSRIs (hazard ratios: 1.843; 1.819) for the established group. Duloxetine initiation was associated with tramadol use, female gender, later dates of diagnosis, chronic fatigue syndrome, and use of non-MD mental health providers; patients seen by chiropractors were less likely to initiate duloxetine. In the established group, those with mental health diagnoses and those visiting rheumatologists were more likely to initiate duloxetine (hazard ratios: 1.756, 1.476; both p < 0.01). CONCLUSION: Physicians type and prior use of APS-recommended drugs were important predictors of duloxetine initiation. Variations in predictors exist among fibromyalgia patients on time to duloxetine initiation from the later of index date (duloxetine market entry (August 1, 2004)) or first fibromyalgia diagnosis.

PSYS2

INADEQUATE GASTROPROTECTION AMONG NEW CHRONIC USERS OF TRADITIONAL NSAIDS IN THE NETHERLANDS
Van der Linden MW1, Kuipers E2, Suelen M3, Van den Bemt BJ4, Herings RM5, Gaugris S6

1PHARMO Institute for Drug Outcomes Research, Utrecht, Netherlands, 2Erasmus University Medical Center; Rotterdam, Netherlands, 3PHARMO Institute, Utrecht, Utrecht, Netherlands, 4St Maartenskliniek; Nijmegen, Gld, Netherlands, 5PHARMO Institute, Utrecht, Utrecht, Netherlands, 6Merck & Co., Inc, Whitehouse Station, NJ, USA

OBJECTIVE: To describe the use of gastroprotective (GP) strategies among new chronic users of NSAIDs in The Netherlands by GI Risk Factor (RF) score. METHODS: From the PHARMO Record Linkage System, including among others linked drug-dispensing and hospital records of approximately three million individuals in The Netherlands, we selected new chronic users of Coxibs or tNSAIDs between January 1, 2000 and December 31, 2004 in The Netherlands. Eligible patients had >=1 year history before the 1st NSAID dispensing and >=1 year of follow-up afterwards. Use of GP strategies was defined as the use of PPI, Coxib or both. Baseline GI RF score was based on: history of GI drug use, high dose of NSAIDs, age >60 years, use of corticosteroids/anticoagulants/SSRI, rheumatoid arthritis, heart failure or diabetes with each condition accounting for one factor. Chronic users were >60 days on therapy during the first year of follow-up. Switching was assessed among those with >=1 GI RF during the 1st year of follow-up. RESULTS: Among 58,770 new chronic NSAID users at baseline, 47,234 (80.4%) used tNSAID alone, 7.9% used tNSAID-PPI, 10.2% used a Coxib alone and 1.6% used a Coxib +PPI. Mean (SD) number of GI RF among these groups was 1.6 (2.1), 3.1 (1.3), 1.5 (1.5) and 2.8 (1.3), respectively. Among 48,390 patients (82.3%) with GI RF score of >=1, 20.9% used a GP strategy, but this increased with the number of GI RF. Within the 1st year, 5.3% (n = 2067) and 4.8% (n = 1843) of tNSAIDs users with >=1 GI RF switched to tNSAIDs+PPI and Coxib alone respectively. CONCLUSION: Gastroprotection in users of tNSAIDs was inadequate. Over 80% of tNSAIDs with >=1 GI RF did not receive any GPA and <5% start one within a year. More research should show if GPA was used for preventive reasons.